Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

GOTTFRIED KAESTNER DO
P O BOX 121589
ARLINGTON TX 76012

Carrier's Austin Representative Box
Box Number 19

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Date Received
May 11, 2012

MFDR Tracking Number
M4-12-2881-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The designated examination was requested to resolve question(s) about the following: **Impairment caused by the employee's compensable injury**…**Attainment of maximum medical improvement**…In this case the reimbursement is not according to the Rule."

Amount in Dispute: $250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please be advised that the bill referenced in this MDR has been sent for reprocessing to our bill review vender. If anything additional will be recommended post-review, it will be issued promptly."

Response Submitted by: Gallagher Bassett Services, Inc., 6750 W. Loop S, Suite 300, Bellaire, TX 77401

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 3, 2012	99456-W8-RE	$250.00	$250.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated February 3, 2012

- 59 – (59) PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.
- W1 – (W1) WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
- BL – TO AVOID DUPLICATE BILL DENIAL, FOR ALL RECON/ADJUSTMENTS/ADDITIONAL PYMNT REQUESTS, SUBMIT A COPY OF THIS EOR OR CLEAR NOTATION THAT A REC

Explanation of benefits dated March 2, 2012

- 59 – (59) PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.
- W1 – (W1) WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
- BL – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL, ALLOWANCE AMOUNTS DO NOT REFLECT PREVIOUS PAYMENTS.

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor billed the amount of $500.00 for CPT code 99456-W8-RE regarding a Division ordered Return to Work (RTW) examination. Review of the documentation supports the services billed. Per 28 Texas Administrative Code §134.204(i)(2)(A) & (k), the Maximum Allowable Reimbursement (MAR) for the Return to Work (RTW) and/or Evaluation of Medical Care (EMC) examination is $500.00.
2. The respondent has previously reimbursed the requestor the amount of $250.00 for the disputed CPT code 99456-W8-RE. Therefore, the requestor is entitled to additional reimbursement in the amount of $250.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $250.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $250.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 19, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.